Hospital Letterhead

Hospital ABN 4.

_____
Date of Notice

_____ _____
Name of Patient Admission Date

_____ _____
Address Health Insurance Claim (HIC) Number

_____ _____
City, State, Zip Code Attending Physician's Name

YOUR IMMEDIATE ATTENTION IS REQUIRED

Dear _____: (*Insert the name of the addressee.*)

This notice is to inform you that we have reviewed the medical services you have received for *(specify services or condition)* from *(date of admission)* through *(date of last day reviewed)*. Your attending physician has been advised and has concurred that beginning *(specify date of first noncovered acute care day)*, you no longer need an acute level of care. You will begin to receive the type of hospital services that are furnished in a skilled nursing facility (SNF) beginning *(specify date of first SNF swing-bed day)*. This is known as SNF swing-bed services. Medicare will pay for your SNF swing-bed services (if you have not used up all your SNF benefit days in the benefit period).

However, this notice is not an official Medicare determination. The *(name of QIO)* is the Quality Improvement Organization (QIO) authorized by the Medicare program to review inpatient hospital services provided to Medicare patients in the State of *(name of State)* and to make that determination.

- **If you disagree with our conclusion and want an immediate review:**

Request ***immediately***, or at any point in the stay, an immediate review of the facts in your case. You may make this request through us, or directly to the QIO at the address listed below.

- **If you do not request an immediate review:**

You may still request QIO review within 30 days after you receive this notice. Request this QIO review at the address listed below.

- **QIO Review Results:**

The QIO will send you a formal determination of the medical necessity and appropriateness of your hospitalization, and will inform you of your reconsideration rights.

IF THE QIO DISAGREES WITH THE HOSPITAL (i.e., it determines that your care is covered by Medicare), you will continue to receive acute care services covered under Medicare. You will continue to be responsible for payment of any applicable amounts for deductible, coinsurance, and convenience services or items normally not covered by Medicare.

IF THE QIO AGREES WITH THE HOSPITAL, you will continue to receive SNF swing bed services paid under Medicare. You will continue to be responsible for payment of any applicable amounts for deductible, coinsurance, or convenience services or items normally not covered by Medicare.

- **QIO Address:**
  (QIO Name)
  (Address)
  (Telephone Number)

Sincerely,

_____

(Title, e.g., Chairperson of Utilization Review Committee, Medical Staff, etc.)

ACKNOWLEDGMENT OF RECEIPT OF NOTICE

This is to acknowledge that I received this notice of noncoverage of services from _____*Name of Hospital*_____ at _____*Time*_____ on _____*Date*_____. I understand that my signature below does not indicate that I agree with the notice, only that I have received a copy of the notice.

_____ _____ _____

Signature of patient or authorized representative Time Date

cc: QIO
Attending Physician